Q1 2025

Provider Newsletter

for Highmark Health Options | Highmark Health Options Duals (HMO SNP) | DELAWARE

FEATURED ARTICLES:

In this issue.

Contact us.

Highmark Health Options and Highmark Health Options Duals Provider Services is the first line of communication for providers' questions and inquiries. Provider Services is available Monday–Friday, 8 a.m.–5 p.m., and can be reached by calling the following numbers:

HHO Provider Service: **1-844-325-6251**

HHO Duals Provider Service: **1-855-401-8251**

When you see this icon, click it to return to this contents list.

Enhanced Claims Processing with Cotiviti Claims Pattern Review (CPR)

In 2025, Highmark Health Options will enhance its existing claim editing program to broaden the overall accuracy and integrity of our claims processing. To enhance the accuracy and timeliness of claims processing, Cotiviti Claims Pattern Review (CPR) will be implemented. CPR will enable efficient Payment Policy Management and review of claims while utilizing "real time" analytics. CPR will have the ability to pause claims processing and enable Cotiviti CPR experts to review claims for proper validation prior to payment. As part of this process, registered nurses with coding certifications will review claim data in conjunction with patient claim history to validate appropriate claims processing.

Where to send Appeals for Claims Pattern Review?

Providers have the right to submit for review any claim they feel was denied or paid incorrectly. Providers will have three options to send in Cotiviti CPR Appeals:

1. Direct upload to the **Secure Portal**. Simply click on the "Submit Records" button and enter your password high90CCVC.
2. Secure faxing to **800-409-0499**.
3. Mailing the records directly to Cotiviti. Please mark the envelope "Confidential" and send to:

   C/O Cotiviti-6150
   10701 S Riverfront Pkwy,
   Box 12017
   South Jordan, Utah 84095

Information regarding Cotiviti CPR will be reflected in the Highmark Health Options Medicaid and the Highmark Health Options Duals Medicare D-SNP Provider Manuals in the near future. Please be on the lookout for these updates using the Provider Page on the **Highmark Health Options website**.

2025 D-SNP Clinical Practice Guidelines

Highmark Blue Cross Blue Shield compiles clinical practice and preventive health guidelines to assist providers in delivering appropriate care relevant to our Highmark Health Options Duals (HHO Duals) (HMO-SNP) members.

These guidelines are developed using clinical practice guidelines (CPGs) from recognized sources. The guidelines also serve as a guide for our various wellness programs.

General CPG Limitations:

- Guidelines may not apply to every patient or clinical situation; some variation from guidelines is expected.
- Provider judgment and knowledge of an individual patient replaces clinical practice guidelines.
- In addition, guidelines do not determine insurance coverage of health care services or products. Coverage decisions are based on member eligibility, contractual benefits, and determination of medical necessity.

A complete listing of Highmark's guidelines for your HHO Duals patients is **viewable online under Clinical Practice Guidelines** on the provider HHO website. Physical copies are available upon request. For a paper copy, please contact the Quality Improvement Department at **1-844-325-6251**.

Coverage for Coronary Computed Tomography Angiography (CCTA) and Fractional Flow Reserve CTA (FFRCT)

Coronary Computed Tomography Angiography (CCTA) and Fractional Flow Reserve CTA (FFRCT) is covered for your Highmark Health Options (HHO) and Highmark Health Options Duals (HHO Duals) (HMO-SNP) patients.

The use of CCTA has been effectively shown to diagnose obstructive coronary artery disease (CAD) and is considered a first line test over non-invasive functional tests such as stress echocardiograms, exercise stress tests, or invasive coronary angiography (ICA).

The use of CCTA as an alternative to stress tests and diagnostic ICA's can substantially reduce the number of unnecessary ICA's, resulting in improved outcomes and decreased costs. Contraindications include prior percutaneous coronary intervention (PCI) or coronary artery bypass graft (CABG), acute coronary syndrome, and complex congenital heart disease.

CCTA Heartflow interpretation can be done through a company called Heartflow. FFRCT sites can be found at the link below and would still be subject to utilization management guidelines.

Heartflow Finder

For your HHO and HHO Duals patients, please consider the use of CCTA and FFRCT when necessary, as a diagnostic alternative when clinically appropriate and available.

Enhanced Community Care Management Program Coming May 1

Highmark is bringing an Enhanced Community Care Management (ECCM) program to Highmark Health Options (HHO) Medicaid and Highmark Health Options Duals (HMO SNP) Medicare D-SNP members beginning May 1, 2025. The ECCM program provides comprehensive support for Medicaid and Medicare D-SNP members, facilitating better health management, improved access to care, and collaborative care team engagement.

What is ECCM?

- Supportive and palliative care for high-risk populations, providing care coordination and specialty medical expertise that collaborates closely with the member's primary care provider (PCP) and focuses on leading patients to live their best lives.
- ECCM's interdisciplinary care team includes physicians, advanced practice providers, registered nurses, licensed social workers, and care coordinators. It provides team-driven care directed by whole-person centered outcomes, such as self-management of patient's chronic conditions, improved quality of life, symptom burden alleviation, emotional well-being improvement, increased communication, stronger continuity of care and decreased caregiver burden.
- ECCM care is provided both virtually and in the community.
- The ECCM team ensures it is meeting patients where they are and matching them with the appropriate resources based on the patients' changing needs.
- The ECCM model is flexible, reducing disruption for the patient, family, and caregiver by providing care during the most complex parts of the care continuum. ECCM is the extra set of eyes and hands in the home to monitor patients more closely when they need it the most.

What This Means for You

ECCM is available at no-cost to your HHO and HHO Duals patients and helps them better manage their condition while maintaining their independence in the community. Home and Community Services will be reaching out to PCPs and other physicians who have eligible members to collaborate how ECCM can help support those patients.

For questions or information regarding this program contact Highmark Health Options Provider Services at **1-844-325-6251** for Medicaid or Highmark Health Options Duals for Medicare D-SNP at **1-855-401-8251** Monday–Friday, 8 a.m.–5 p.m.

Enhanced Community Care Management by Endorsed LLC is a separate company working with Highmark Health Options and Highmark Health Options Duals (HMO SNP) that offers specialized care coordination and/or supportive care.

Provider Directory Information is Verified Through the CAQH Directory Management Solution

Highmark Health Options requires all network providers to verify their provider directory information every 90 days. This process allows us to comply with CMS requirements to maintain accurate directories and ensure our members can find in-network care as quickly as possible.

Highmark Health Options partners with the CAQH Directory Management Solution to manage this provider directory attestation process. This solution helps simplify the process for providers.

To complete this attestation, providers should perform the following tasks:

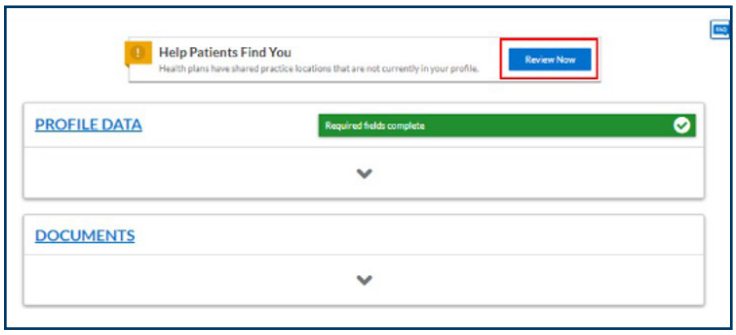
1. If you already are registered with the CAQH Provider Data Portal, **log in here**. Ensure that Highmark Health Options is authorized to receive your information on the Authorize tab, by enabling the "Highmark Government Markets" plan name.

   OR

   If you are new to the CAQH Provider Data Portal, **register here**. You will then need to gather credentialing information and **log in** to complete your profile and upload needed documents. Be sure that Highmark Health Options is authorized to access your information on the Authorize tab, by enabling the "Highmark Government Markets" plan name.

   Attestation information, including your current Provider Status, is displayed directly below the top navigation menu for new users. Upon your first login, first complete your Profile Data, then review and attest.

2. You will receive a “Help Patients Find You” banner notification on the Home tab or an email notice if you have new addresses to accept or reject. These new addresses occur when the provider directory data you have documented in CAQH differs from what Highmark Health Options has on file. Please click the notification to confirm the new address, reject the new address, or add corrections to address, phone number, email address, fax number, and any other directory information.



3. Every 90 days, you will need to re-attest to your provider directory information. The notification directly below the top navigation menu will let you know how many days until your next attestation must be completed. Please promptly review and attest, to ensure we have accurate directory information for you.

If you have any questions, please review the **CAQH Provider Data Portal User Guide** on your login page, visit the **Help page**, or contact CAQH through their live chat or by calling **888-599-1771**, Monday–Friday, 8 a.m.–5 p.m.

Thank you for helping us ensure our members have access to the care they need!

**If you have a delegated credentialing relationship with us, there will be no need to log into CAQH. Please continue with your current roster process.*

Important Changes for the Adult Pneumococcal Vaccination

The Centers for Disease Control and Prevention (CDC) has broadened vaccination recommendations, and a new adult pneumococcal vaccine has entered the market. These changes introduce additional nuances when selecting the appropriate vaccine for each patient.

Expanded Vaccination Recommendations

The CDC now recommends pneumococcal vaccination for adults ages 50 and older, which is a change from the previous recommendation for adults ages 65 and older. Vaccination for adults ages 19 to 49 remains recommended for those with risk factors or immunocompromising conditions.

A New Vaccine is Available: PCV21 (Capvaxive)

PCV21 (Capvaxive) has recently been approved and offers broader protection than the existing PCV20 (Prevnar 20) vaccine – it covers 10 of the same serotypes and an additional 11 serotypes. These include eight serotypes not found in any other vaccine, which contribute to 30% of invasive disease in patients ages 50 and older. All this translates to improved coverage of invasive pneumococcal disease (77-85% with PCV21 versus 54-65% with PCV20).

However, it's crucial to note that PCV21 does not cover serotype 4, which is covered by PCV20 and PCV 15 and is a significant cause of invasive disease in the Western U.S.

Choosing the Right Vaccine

Selecting the appropriate vaccine can seem complex, but the CDC's **Pneumo Recs VaxAdvisor App** and **website** offer helpful guidance.

Here's a simplified guide:

- **PCV21:** Suitable for most adult patients ages 18 and older. Offers superior overall serotype coverage. One dose will get patients up to date.*
- **PCV20:** Appropriate for most children and adults. Remains a valuable option that covers serotype 4. One dose will get patients up to date.*
- **PCV15 (Vaxneuvance):** Another option for vaccine-naïve patients, but typically requires a second dose with PPSV23 (Pneumovax23) a year later.

***This includes patients:**

- With no prior pneumococcal vaccination.
- Previously vaccinated with PPSV23 or PCV13. Generally, a one-year waiting period after PPSV23 or PCV13 is recommended before administering PCV20 or PCV21.
- Who received PCV13 and PPSV23 before age 65.
  - These patients may require PCV20 or PCV21 after five years; if PPSV23 was administered at age 65 or older, a risk/benefit assessment should be considered.

Coverage of Pneumococcal Vaccines

- **Highmark Health Options (HHO):** Covered at the pharmacy or provider office without restriction for members ages 19 and older with a $0 copay. Members ages 18 and younger should be vaccinated through the Vaccines for Children program.
- **Highmark Health Options Duals (HMO SNP):** Covered under Part B with no coinsurance. Administration at a physician's office or a Medicare Part B-participating pharmacy is permitted.

We encourage you to track these updates, so you can ensure your patients receive the most appropriate and effective pneumococcal vaccination. We are here to support you in providing your patients vital, optimal care.

Coding Corner: Coding For Assisted Living Facilities

On January 1, 2023, CPT codes 99324–99343 for domiciliary, rest home, or custodial care services were eliminated. This means a change in how we bill for Evaluation and Management (E/M) services provided in assisted living facilities.

Clarifying "Home"

To bill for "home visit codes" effectively, the provider must document that the patient was seen in the home (in a private residence) and not in the office. The CPT definition of "home" includes a wide range of locations. The official coding definition of the Home and Residence services states, "Home may be defined as a private residence, temporary lodging, or short-term accommodation (e.g., hotel, campground, hostel, or cruise ship)."

What Codes to Use Now?

To accurately bill for E/M services performed in assisted living facilities, you must now use the appropriate E/M codes:

- 99341-99345 for new patients
- 99347-99349 for established patients

Select the level based on the complexity of your service and documentation. These codes should always be matched with the appropriate place of service (POS) code.

The appropriate codes to bill for evaluation and management of a member in the assisted living facility are:

- **99341:** Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
- **99342:** Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

- **99344:** Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
- **99345:** Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
- **99347:** Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
- **99348:** Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- **99349:** Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

Understanding Place of Service (POS) Codes

Correctly identifying the POS code is critical, the key is specifying that the service occurred in an assisted living setting, not in a home or another healthcare facility.

These POS codes all apply to the 99341-99349 code sets:

- 12 Home
- 13 Assisted living facility
- 14 Group home
- 16 Temporary lodging
- 33 Custodial care facility
- 55 Residential substance abuse treatment facility

Accurate coding helps ensure your claims are processed timely and successfully.

Your Corrective Action Plans Support Compliance

Corrective Action Plans

The Financial Investigations and Provider Review (FIPR) Team conducts audits regarding **fraud, waste, and abuse (FWA)**. An audit that identifies errors will require corrective actions, including a Corrective Action Plan (CAP) to address and resolve the deficiencies. Providers are responsible to correct areas of noncompliance.

An effective CAP will:

- Specify steps to remediate the underlying problem, including identifying timeframes of implementation and staff members who are responsible for changes.
- Improve processes so that outcomes are more effective and efficient.
- Include methods to monitor the effectiveness of the changes.

Providers are expected to submit a CAP when requested within 30 days. CAPs should be reviewed and acknowledged by a Notarial Official. Subsequent FWA audits may be performed to measure CAP adherence.

For more information regarding FWA audits and corrective actions, please review the **Highmark Health Options Medicaid Provider Manual** and the **Highmark Health Options Duals (HMO SNP) Provider Manual**.

If you have any questions or would like to report fraud, waste, and abuse, call the FWA hotline at **1-844-325-6256** or email the Special Investigations Unit (SIU) at **SIU_HHO@highmark.com.**

Get Care, Get Rewarded: TheraPay Healthy Rewards Program for Your Patients

Your Highmark Health Options (HHO) and Highmark Health Options Duals (HHO Duals) (HMO-SNP) patients can earn rewards (ranging from $10-25) in 2025 when they complete eligible health care activities which can include:

- A1c test (only for patients with diabetes)*
- Annual wellness visit (ages 20 and older)*
- Annual well-child visit (ages 3-19)
- Asthma controller medicine fill (ages 18 and younger; up to 6 fills)
- Breast cancer screening*
- Cervical cancer screening*
- Colorectal cancer screening*
- Follow-up visit after hospital admission (if seen within 14 days post discharge)*
- Lead screening (up to age 24 months)
- Postpartum doctor visit (up to 84 days after delivery)
- Retina exam (only for patients with diabetes)*
- Well-baby visit series (through age 30 months; up to 8 visits)

*Denotes HHO Duals member eligibility

Upon completing any number of the eligible activities, HHO and HHO Duals members will be asked to provide proof of claim from your office. Once completed, the amount members earn will be provided on a reloadable Rewards credit card mailed directly to them.

Completing routine exams and screenings allows your patients and their covered dependents to experience improved health outcomes and care quality and can close gaps in their care. We encourage you to speak with your Highmark HHO and HHO Duals patients about enrolling in the Healthy Rewards Program.

To view their eligibility and enroll, members can go online at **my.therapayrewards.com/hho** or call Healthy Rewards at **1-866-469-7973**.

HHO and HHO Duals members will be asked to complete eligible health care activities and provide proof of claim from your office.

Thank you for your commitment to our Highmark HHO and HHO Duals members.

CAHPS and Patient Satisfaction

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey is a tool that collects information about patients' health care experiences. The survey allows patients to disclose their thoughts about their health plan, which includes various aspects of care from doctors, provider practices, and health care facilities.

Survey results are used to:

- Elevate the standards of patient-provider relationships.
- Identify key areas to provide better clinical care.
- Improve the delivery of services.

There are many ways you and your office can help influence CAHPS scores, including:

- Following up with prior authorization decisions and test results in a timely manner.
- Assisting with scheduling appointments with specialists.
- Leaving a few appointment slots open each day for urgent care walk-in visits.
- Offering brief explanations when running late is unavoidable.

Highmark Health Options members will be surveyed during March and April. The results will be available by late summer.

Cervical Cancer Prevention and Early Detection

January was recognized as Cervical Health Awareness Month, highlighting the critical importance of cervical cancer screenings.

The progression of cervical cancer is frequently associated with infection by the human papillomavirus (HPV), a prevalent sexually transmitted virus. HPV can persist in the body for an extended period and may result in the transformation of cervical cells into malignant cells. Given that cervical cancer may not exhibit any symptoms during its initial stages, it is essential to engage in discussions with Highmark Health Options (HHO) members regarding the necessity of regular gynecological examinations and HPV screenings.

Symptoms of cervical cancer can include:

- Atypical vaginal bleeding
- Discomfort during sexual intercourse or following menopause
- Pelvic pain
- Prolonged or excessively heavy menstrual periods

Furthermore, clarifying that if your patients present these symptoms, it's beneficial to inform them of the diagnosis process which includes a pelvic examination augmented by a Pap test and an HPV test, followed by confirmation via biopsy.

The available treatment options are contingent upon the stage of cancer at the time of diagnosis. Prevention remains paramount. It is advisable to initiate discussions with HHO members regarding the HPV vaccine, the importance of consistent Pap and gynecological examinations, and the adoption of preventive measures against sexually transmitted infections.

Highmark Health Options provides a financial incentive for cervical cancer screenings through its Health Rewards Benefits program. Individuals are encouraged to register and explore the potential rewards available by visiting **my.therapayrewards.com/hho** or by contacting **1-866-469-7973**.

More information on cervical cancer can be found at **mayoclinic.org**.

Earn Incentives by Submitting the Obstetrical Need Assessment Form (ONAF)

Providers who see pregnant Highmark Health Options (HHO) patients during their first trimesters can earn an incentive of $100 for completing and submitting an Obstetrical Need Assessment Form (ONAF).

To receive the incentive, Highmark must receive the ONAF to process the claim. Complete the ONAF with the patient's demographic and clinical information in its entirety including:

- Date of prenatal visit
- Gestational age
- Estimated date of delivery
- Medical condition risks

Completed ONAFs should be faxed to HHO at **1-855-501-3903**.

To receive the incentive for submitting an ONAF, providers must bill the following codes on the same claim form:

Incentive	Requirements
Outreach bonus: $100 for an intake with completed form during the first trimester.	• Procedure codes for first trimester outreach (99429-HD) and initial risk assessment (T1001-U9) must be reported together on the same claim form. • Include the appropriate evaluation and management codes (99202-99215) and HD pricing modifier on the claim form.
Intake visit: $50 for an intake visit with completed form.	• If the patient's first prenatal visit does not occur within the first trimester, code 99429-HD should not be billed. • At the intake visit, an ONAF must be completed and faxed to HHO, and a claim submitted with code T1001-HD for reimbursement. • The appropriate evaluations and management code and pricing modifier should also be included on the claim form.

Providers can contact Maternity Care Coordination at **1-844-325-6251** for more information regarding the ONAF.

Preventive Diabetic Eye Exams

The annual diabetic eye exam for diabetic eye diseases, such as diabetic retinopathy, not only monitors the overall health of patients with diabetes, but it can also improve quality measure compliance rates.

The comprehensive annual dilated eye exam is considered a standard of care for patients with diabetes; however, most patients do not get a retinal scan for diabetes annually. Providers can identify at-risk patients early and can reduce the risk of vision loss by performing a diabetic eye exam as a routine annual diagnostic at their primary care office.

Remind your Highmark Health Options patients that they may be eligible for a monetary Healthy Reward if they receive this screening.

If you have questions about detecting diabetic retinopathy, please contact our Quality team at **1-844-325-6251**.

Working Together to Lower Your Diabetic Patients' A1c

As a provider, you know the importance of keeping your diabetic patients' A1c levels low. Even with regular blood tests, your patients may not fully understand the dangers of high A1c and blood sugar levels and how to lower them.

During routine and follow-up visits, remind your patients about the risks of prolonged high blood sugar levels, such as nerve damage and cardiovascular disease, and how lowering A1c levels can help slow the progression of diabetes.

Educate patients on the following lifestyle changes they can make and how it can impact their A1c levels:

- Adhering to their diabetes treatment plan
- Regular exercise
- Varied diet/food plan

When it comes to an A1c target range, there is no one-size-fits-all solution. Providers should discuss a suitable target for their patients with diabetes. The American Diabetes Association notes that the goal for most adults living with diabetes is an A1c of less than 7%. Many factors, including the type of diabetes and general health, can affect an A1c goal.

Help Reduce Hospital Readmissions

Readmission rates are one measure of hospital care quality. Highmark Health Options offers an incentive reward to the member if the member is seen within 14 days of a hospital discharge.

Providers can remind patients about this reward to help them follow through on the important follow-up visit that is an important component in addressing readmission rates.

Five readmission rate reduction strategies for providers.

1. **Identify High-Risk Patients:** Certain patient populations are at higher risk for hospital readmission. Socioeconomic factors, such as race, income, and payer status, are correlated with rehospitalization rates. In addition, patients with certain conditions, including heart failure, chronic obstructive pulmonary disease, and renal failure, have higher rates of readmission. Providers can take additional steps to minimize high-risk patients' chances of readmission. They can involve the patient's family in post-discharge care instructions or refer the patient to a specialist for further care.
2. **Ensure Adequate Nursing Coverage:** There is a correlation between the number of nursing staff at a hospital and its 30-day readmission rates. When staff levels are higher, nurses have more time to spend with each patient, ensuring more comprehensive communication. This often increases the quality of discharge instructions provided. Another component of ensuring adequate nursing coverage should be offloading nonclinical activities from nursing staff to appropriate nonclinical personnel. This helps ensure that clinical staff are able to focus on patient care.
3. **Improve Transitional Care:** Transitional care may include rehabilitative, restorative, or skilled care, physical therapy, nutritional counseling, and dietary planning, fall prevention, and more. These services are especially useful to patients with complex or chronic conditions. You and your staff can help ensure a smooth transition of care by providing clear communication and documentation of the patient's condition, treatment and follow-up plan, and medication(s) to their providers, care team, and/or caregiver.

4. **Ensure Patients Understand Post Discharge Instructions:** When patients misunderstand or forget parts of their post-care directions, the misunderstood instructions can greatly increase their risk of being readmitted to the hospital in the near future. Providers can use the "teach-back" method, in which patients are asked to explain their own care instructions back to providers. This allows providers to assess whether patients fully understand the steps they need to take post-discharge.
5. **Schedule 7-Day Follow-Up Appointments:** Programs like the 7-Day Pledge can help ensure that patients are following up with their primary care providers, who can help patients with medication reconciliation, reviewing their discharge plan, and providing any additional information needed for a smooth care transition.

Providers can contact the Quality department at **1-844-325-6251** to learn more.

Improve Quality Measures with Perinatal Screenings

As a reminder, you can help impact quality measures by performing perinatal screenings for your Highmark Health Options patients by asking about (and documenting) the following:

- Exposure to environmental smoke
- Intimate partner violence
- Medications they are taking (prescribed and over-the-counter)
- Prenatal and postpartum depression (document the referral, when applicable, with notation of the depression scale used)
- Tobacco, alcohol, and illicit drug use (document the counseling or referral, when applicable)

Perinatal guidelines recommend:

- A minimum of one prenatal visit within the first trimester visit (or 42 days of enrollment).
- Regular prenatal care visit throughout the pregnancy.
- A postpartum visit seven to 84 days after delivery.

Perinatal screenings can help reduce:

- Poor birth outcomes
- Low birth weights
- Infant and maternal mortality rates

For more information about conducting and/or documenting perinatal screenings for your Highmark Health Options patients, please contact our Care Coordination team at **1-844-325-6251**.

Accessibility Standards

Highmark Health Options (HHO) Delaware maintains standards and processes for ongoing monitoring of access to health care.

To help ensure our members receive services in a timely manner, practice sites are contractually required to follow these standards. Please take a few minutes to **review the accessibility standards** and share with your office staff that schedule member appointments, including off-site central scheduling and call center staff.

These standards and additional resource information related to accessibility are available on our **HHO provider website**.

Participating Providers Should Not Balance Bill Patients

Highmark Health Options (HHO) continues to receive numerous complaints about participating providers who have inappropriately balance billed HHO patients for services.

As a reminder, reference the below language from page 19 of the Highmark Health Options Provider Manual Billing Responsibilities section.

Billing patients for covered services

Under no circumstance may a provider bill; charge; collect a deposit from; seek compensation, remuneration, or reimbursement from; or have any recourse against a patient for nonpayment by Highmark Health Options for covered services.

Contact Provider Services at **1-844-325-6251** to learn more about balance billing.

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Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

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